Issue 6 October 2003

network

SMMGP SUBSTANCE MISUSE MANAGEMENT IN GENERAL PRACTICE

A national newsletter on substance misuse management in primary care

What does the new GMS contract mean for patients and GPs?

A personal view from Dr Clare Gerada, RCGP lead in drug misuse

So the new GMS contract (nGMS) has finally been accepted and will be implemented from April 1st 2004. As the RCGP lead in drug misuse I am often asked to give my views on 'what it means for us'. I do know that I am unhappy about placing drug use and therefore drug users in a special category in nationally enhanced services (an opt-in service) rather than additional services (an opt-out service).This places a dowry on drug users heads and removes their care away from mainstream general practice, something that for years, myself and many others involved in leading primary care drug misuse have fought against. The drug strategy aimed to involve all general practitioners in the care of drug users, something that the new GMS contract undermines. We now have a situation, where prescribing will be separated from care and GPs can legitimately refuse to manage these patients.

So let me take you through what I think the new GMS contract means. I must stress that these are my thoughts, not those of the RCGP. The practicalities of the new contract, or how it is to be funded, monitored and other process issues have yet to be fully understood.

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The new GMS contract. The new GMS divides our work into 3 main parts:

Core work – acute illness and terminal care which all GPs must provide.

Additional services – chronic disease management, vaccinations, contraception – all GPs must provide unless they can give the local PCO a very good reason to opt out.

Nationally enhanced services (NES) - which need to be provided in each locality but not by every GP – this is very much an opt in service and includes many specialist services and drug misuse, alcohol and sexual health services, all which I would argue should be mainstream and not only provided by a few!

What does it mean for our patients?

Advantages out-weighed by disadvantages? The advantages may be better care, delivered by more committed and better-trained professionals – paid to deliver evidence based care. However, I fear the disadvantages, if not properly addressed, may out-weigh the potential gains. I have stated my first anxiety – making drug users different worries me as it marginalizes them, making the care of drug users fragmented and separated from mainstream GMS. I feel this is a retrograde step leading to reduced patient access and choice as there may not be such a spread of services, and reduced access to general health care and normalised settings.

I entered this work at a time that most drug users were looked after by a very small number of GPs – the statistics being 50% of users by 5% of GPs – this meant that those who did look after drug users risked being overwhelmed and burn-out. This could apply again within NES which once again places drug users in a special category.

My second anxiety is the money. Like the rest of you I want to earn an honest living, and many of us have been doing this for nearly two decades. We know the work does take time and should be valued, but did the negotiators price it so high so PCOs could not afford it? Should not the care

of drug users be part of modern general practice? I have calculated that within my own PCT around £300,000 of new money will need to be found just to stand still, not to invest in more care, just to pay for what already goes on, and what already goes on in a seamless, supported manner through a well established shared care service. I do not feel my PCT will find that money, and even if they do, will they invest it in general practitioners, who after all are only a small part of the overall care provided to drug users? To answers my own question, I do not think they will, if I were a PCT Chief Executive I would now be looking for more cost effective means of treating drugs users and certainly would look to expanding the roles of nurses, pharmacists, expert patients, big satellite clinics and specialists, rather than GPs caring for their own patients. Perhaps one way forward is for the NES money to enter a pooled budget that could provide additional payments to GPs, some to pay for GPwSIs to support shared care, some to provide training and some to support other shared care professionals providing services – but by more flexible local arrangement.

I am concerned that we are heading towards 'drug practices' where a few GPs are commissioned by PCTs to provide care to, perhaps hundreds of drugs users. This may not be the most effective way to provide care to patients but there are also implications in terms of professional development. I think that even those like myself, who enjoys and leads in addiction services, entered general practice primarily because the work is varied. We see patients with a whole range of problems and we enjoy this work because of its variety and because it is family medicine. I do not want to be a drug addiction consultant, I am a generalist and this generalist role may well be eroded if drug users are going to get any care at all from general practice.

Opportunities - As a pragmatist I believe there is always a silver lining. We can for example look forward to more improved care from general practitioners, as they will have to engage in training and continuing professional development if they are to qualify for payments. The RCGP and SMMGP are developing a *Part 1 to the Certificate* course that could be the recognised accreditation for this. Better training and service level agreements will at last mean that there will be a mechanism for ensuring drug users have access to evidence based care, including appropriate dosages of substitute medication, immunisation and better care for concomitant physical, social and psychological problems. It may be that the additional resources available are for the whole primary care team, and not just the GP, so the new money would be welcome in boosting services available to drug users, at last I would be able to buy psychological support for them, and maybe a dedicated social worker.

Ways forward - I think the next steps, and fairly rapidly at that, should include a meeting of key stakeholders, the RCGP, DH and NTA to try and map out the way ahead. We need to determine between us, not just the problems but also the solutions to the nGMS contract. We need to find a way of ensuring that patient care is not compromised. I think we need to ensure that we are able to give commissioning advice to PCTs based on current good practice models of shared care and that we must map, from a patient's point of view, their journey into treatment and where the potential barriers may be. I am sure with the history of this area of work and the dedication and creativity of GP involvement, we will find a way through to use these extra resources to improve patient care. After all, we may even end up with better services.

GP Lead appointed to the new NTA Clinical Team
Dr Nat Wright has been appointed to the GP Clinical Lead post at the NTA as part of their new clinical team. Nat is a GP committed to the management of drug users in general practice and has worked in Leeds with both patients in general practice and in the development of the No Fixed Abode PMS project for the homeless. Nat has been an active member and participant of the SMMGP network, the national conference, a contributor to NETWORK as well as sitting on the SMMGP advisory group. We fully support this new role which will no doubt provide a great opportunity for the NTA and primary care to work in close partnership around treatment and policy matters.

Hot Topic

Hidden Harm - Responding to the needs of children of problem drug users

This excellent ACMD report focuses on children in the UK with a parent/s or guardian whose drug use has serious negative consequences for themselves or those around them.

Six key messages from the enquiry:

- **We estimate there are between 250,000 and 350,000 children of problem drug users in the UK – about one for every problem drug user.**
- **Parental problem drug use can and does cause serious harm to children at every age from conception to adulthood.**
- **Reducing the harm to children from parental problem drug use should become a main objective of policy and practice.**
- **Effective treatment of the parent can have major benefits for the child.**
- **By working together, services can take many practical steps to protect and improve the health and well-being of affected children.**
- **The number of affected children is only likely to decrease when the number of problem drug users decreases.**

The full report and Executive Summary can be obtained from prolog.uk.com, telephone: 0870 241 4680 or online from

www.drugs.gov.uk/ReportsandPublications/YoungPeople

Substance misuse services in Gateshead - a GP's perspective

For the twenty-first century GP who tries to respond to the needs of the local community and patients coming through the door, **it seems to me that a generic involvement with addictions is a core skill. It is of significance that as the new GP contract comes into being drugs and alcohol are present as enhanced services.**

Like many other areas throughout the country the shift in confidence and response to our local community has occurred with a movement of services out from large central providers to primary care. In Gateshead this occurred about five years ago when we commissioned a change of services from our local provider to a more GP led service. There is no doubt that the pioneering work done by Chris Ford and others and the help from the yearly conferences at the RCGP on substance misuse greatly influenced our model.

The movement of services however was not without much pain, in particular for the large local service, which lost a lot of commissioning money. For anyone involved in reengineering services it is always much easier doing it with new money, but to use existing pots of money and redistribute it amongst existing providers is always more difficult.

Over the last four years we have seen the move from the occasional GP prescribing methadone, to nearly 80% of GP's in Gateshead prescribing it. **I think one of the key factors was the confidence we had watching other areas do similar pieces of work, and paradoxically the fact that we had no secondary care input into our service. It meant we had to build a primary care led substance misuse service up from the bottom.** At times this felt a little bit risky but borrowing a metaphor from complexity theory, I believe it 'freed the system up' to develop into the successful one we have today.

In the early days like many others we were fixated on keeping doses of methadone relatively low and certainly never above 50mg and we were very strict on supervised consumption all the time. **The move to more high dose methadone along with the current evidence has been slow progress. It still feels counter intuitive to be prescribing in the 100mg area, knowing this is safer and less liable to lead to drug deaths.** This highlights how difficult it is to have one's practice challenged.

At the present time in Gateshead we have about 80% of GP's prescribing and have excellent partnership workings with the voluntary sector and our local statutory service Twenty Four 7. **It feels as if the pariah of addictions has come in from the cold, and begun to be managed as a typical chronic disease model.**

The challenges I feel that remain with us in our present service remain the problem of alcohol and our lack of a national strategy and the ever present problem of benzodiazepines.

This leads me into the future prospects for Gateshead. **If the new GP contract comes off I have a hunch we could be into a golden era of primary care addictions. Thank goodness that substance misuse is there as an enhanced service.** And an even bigger three cheers for alcohol being in as its own separate service. My main concern is around the funding of enhanced services and how PCT's are going to afford them all. But never mind at least it is there in writing.

I am sure as the years pass by we are coming to reengineer ourselves as general practitioners and delegate more and more of the work to others, in particular nurse practitioners. I am sure it is going to leave us with more complex and difficult consultations and surely addictions will be part of this. It is often in the distress of those who face crisis, as we often see in addictions, that the disturbance of society itself is expressed. It is hardly surprising therefore that we don't often want to engage with a reminder of the failings at the heart of our own existence.

Embracing addiction work and many of the other difficult areas of primary care remain I am convinced, part of being an authentic GP, particularly so in Gateshead.

Dr Paul Cassidy,
GP in Gateshead

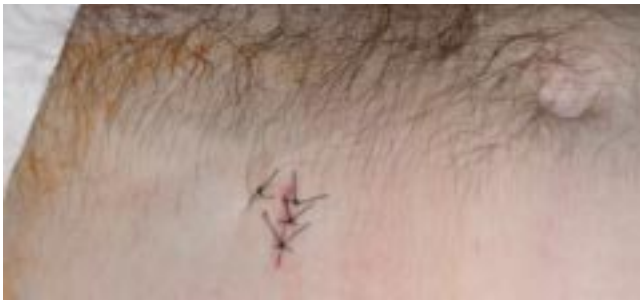
NEXT ISSUE – article by Paul Stanley of Twenty Four 7 in Gateshead giving an overview of bold changes within a GP led specialist service; the success of involving 79% of GPs in a shared care scheme, pharmacy and user involvement, and the reduction in waiting-times from 6 months to 6 weeks

Naltrexone tablets or implants?

A pathway out of addiction?

What is naltrexone? Naltrexone is an effective blocker of opioid receptors. It blocks the euphoric and pain relieving effects of all opioid drugs (though can be pushed off the receptor by high dose buprenorphine). Naltrexone also seems to have an anti-craving effect. This effect does not seem to be specific to opiates, but there is mounting evidence that it is also effective against alcohol and possibly cocaine. Naltrexone can help prevent relapse into opiate addiction and comes in tablet (licensed for the treatment of drug dependency) and implants (not licensed for the treatment of drug dependency) form.

Who would be suitable for naltrexone? The jury is still out about the usefulness of naltrexone in preventing relapse. Each client seeking to become drug free must be assessed on an individual basis to determine their motivation and support networks before deciding to prescribe naltrexone tablets. My personal view is that implants could be considered for clients that have previously relapsed into drug use within six months of detoxification.



Implants are inserted under local anaesthetic

What are the problems with naltrexone tablets? The majority of opioid users stop taking their tablets after only a couple of weeks on naltrexone. The reasons for this are complex. In some cases there is a desire to use again; others feel that they are now "free" from their addiction. Studies consistently show rapid relapse into addiction within the first twelve months (about 80%). Supervision of naltrexone and the use of a contract (as with antabuse) may help with compliance, but this has not yet been shown by research.

Because naltrexone effectively displaces all opioid drugs the client now has absolutely no tolerance to opioids. The half life of naltrexone is under 24 hours so the patient is extremely open to overdose if they return directly to their usual heroin dose after stopping naltrexone. Patients must be warned about this before starting any form of naltrexone.

Why implants? There are two main reasons for using an implantable form of naltrexone. Firstly compliance is greatly enhanced. Secondly the tail off period, where serum drug levels are reducing, is much slower. The second point is crucial as there is theoretically a much reduced chance of accidental overdose should relapse occur.

Currently the only proven medical tool available to doctors wishing to help clients with an opiate addiction is substitute prescribing. Detoxification alone provides very few with a pathway out of addiction. There are many clients who do not wish to start or continue with substitute prescribing but who have failed to sustain abstinence after detoxification. Residential rehabilitation seems to have a higher success rate, but there are doubts whether this is maintained once discharged. Naltrexone implants offer the chance for the client to know that they will be drug free whilst continuing to live in the same community. From a psychological perspective the client is more likely to learn appropriate coping strategies if they are given the chance to face triggers whilst chemically protected for a prolonged period of time. Clients talk of the need to have at least two years protection. It is too early to say what will happen once the implants run out. Many clients opt to continue with further implant.

Who currently uses the implants? Two durations of implants are currently available: six weeks and six months (the latter can be extended to twelve months by putting a "triple implant" in place). In the UK, USA and Australia, use of the implants is currently mainly in the private sector. Some GPs have started inserting implants on the NHS in the UK, but this should only be undertaken by people who have the required knowledge and experience of both their use, addiction and minor surgery. Practice varies with clinicians using different regimens. Some go straight for the twelve month implant, others prefer to give the client a trial of the six week implant before committing to being opiate free for a longer period.

A feasibility study of naltrexone implants has been carried out at Drugs North West (BSTMHP NHS Trust) and has recommended that a multi centre trial be carried out. A depot form of naltrexone is currently being developed, but there is no timescale for its release.

Cost - It is my personal view that the benefits of a year free from opiate addiction cannot be costed. The cost of the six-week implant is roughly £170 and the twelve-month implant roughly £800. This should be compared with the cost of detoxification, rehabilitation etc rather than the simple costs of methadone. For clients on daily pickup, observed or not the costs are comparable.

What are the problems with implants?

1. **Risks associated with minor surgery.** Both primary and secondary infections may occur.

Scaring can be a major issue if the 6 week implants are used recurrently.

2. **Local reaction to the implant.** Some patients develop localised swelling and redness. This usually represents local inflammatory reaction and can be treated with oral steroids (prednisolone) or antibiotics. The reason for using steroids is that the local reaction is primarily immunological. The infection, if any, is secondary. The majority of cultured samples show no infection. Thus steroids should be first line and antibiotics second line. Less than 1% has needed removal at sites where the implants are commonly used. Removal can be difficult due to softening of the implant.

3. **Systemic reaction to the implant**. As with any drug, reactions can occur. The implants can rarely provoke allergic reaction to naltrexone or other constituents. It is recommended that the client has had at least two weeks of oral naltrexone prior to considering an implant.

How is the implant inserted? Implants are inserted using a "no touch" technique, under local anaesthetic. A small incision is made in the lower abdominal wall. A pocket for the implant is the tunnelled by blunt dissection subcutaneously. Some clinicians give prophylactic antibiotics to minimise the chance of infection perioperatively. Implants come in insertion devices.

The six week implant is a cylinder approximately 2cm x 0.5cm. The longer acting implants come as pellets about 0.5cm x 0.5cm. Twenty are inserted for 6 months cover and thirty for 12 months cover. The implants are easily palpable under the skin, but cause little discomfort. Most clients find the palpability reassuring rather than a problem. The implants do not need to be removed at the end of the treatment period and are gradually absorbed by the body.

'No touch' naltrexone insertion devices containing implant pellets

Medico-legal aspects (advice from the Medical Protection Society). Naltrexone tablets are currently licensed for use in addiction. The implant device is not licensed. Doctors are free to prescribe any medication that they feel is beneficial to their patients. Drugs are used outside of their license e.g. aspirin for cardiovascular reasons or dihydrocodeine for opioid detoxification. The doctor needs to take responsibility for the prescription. They must feel equipped to discuss the potential benefits and risks involved. For implants the GP should be trained to insert the implant or know where to refer on locally, and arrangements should be in place for removal if requested. An appropriate consent form should be used which includes information about the lack of licence, side effects, possible difficulties with removal and risks associated with minor surgery.

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Multi-centre trial of naltrexone implants

Dr Cockayne is organising a multi-centre trial of naltrexone implants to assess their effectiveness and appropriateness to UK treatment. If you are interested please email her at lucindacockayne@aol.com with the title "Implant research".

Druglink magazine – subscribe on line

Druglink magazine, produced by DrugScope, is an excellent resource widely read in the drugs field but not so widely known in primary care. We recommend it to all primary care practitioners interested in substance misuse. It is a bi-monthly magazine aimed at UK professionals interested in drugs and drug-related issues whether it is treatment, public health, education and prevention, criminal justice or international. Druglink includes the latest news, feature articles, interviews, factsheets, reviews and listings.
Subscription can be completed on line at £55 per year.
http://www.drugscope.org.uk/druglink/default.asp

Paper review

Gibson A.E., Doran C.M., Bell J.R., Ryan A., Lintzeris N.A.,
Comparison of buprenorphine treatment in clinic and primary care settings: a randomised trial.
Medical Journal of Australia 2003; 179(1): 38-42

Whilst research has identified buprenorphine to be a more effective medication than symptomatic medications (such as clonidine, benzodiazepines) in treating heroin withdrawal, all previous studies had examined treatment delivered in specialist settings. However a considerable proportion of heroin detoxifcation in Australia is delivered in primary care settings. This study compared the outcomes for 115 heroin dependent individuals randomised to receive a one-week detoxification episode using buprenorphine either in a primary care setting or in a specialist addiction outpatient clinic. After one week, patients could then choose from a range of 'post-detox' treatment options and were followed up over the next 3 months. The general findings indicate no significant differences regarding heroin use, treatment retention or cost effectiveness between the two groups, suggesting that heroin detoxification can be safely and effectively delivered by general practitioners in primary care settings.

Strang J., et al.,
Loss of tolerance and overdose mortality after inpatient opiate detoxification: follow up study.
British Medical Journal 2003; 326: 959-960

This really important paper found that patients who completed inpatient detoxification were more likely to die than patients not undergoing detoxification. Over 20 months 137 consecutive opiate addicts were followed after in-patient detoxification. Five patients died within 12 months and 4 of them were in a group who had 'lost tolerance' i.e. who had completed the detoxification and the inpatient treatment programme, 3 from overdose and 1 from renal failure. The other patient who died had completed the detoxification but not the inpatient treatment programme. There were no deaths in those who failed to complete the detoxification. Although heroin use is known to increase mortality, the authors conclude by questioning the deaths in the completed group, indicating reduced tolerance and consequent unpredictability of resumed heroin use.

Vorma H, et al.,
Treatment of out-patients with complicated benzodiazepine dependence: comparison of two approaches.
Addiction 2002; 97 :851-859.

The authors randomised 76 benzodiazepine dependent patients to receive 'traditional' dose taper treatment or an experimental protocol involving fixed rates of withdrawal and psychosocial supports. The patients presented to four addiction clinics in Finland with the experimental condition being implemented by one of these clinics. About half had used 40mg diazepam equivalent daily or more, most had used sedatives for an average of 7 years and over 80% had previously tried to quit. 80% of each group had anxiety, depression and / or alcohol misuse and there was daily or binge drinking in about 30% of subjects. Two thirds had a personality disorder, leaving only 5-10% without a formal psychiatric diagnosis. There were no significant differences between the randomised groups.

The experimental plan included a fixed diazepam or equivalent taper based on the patient's dose and proportionate reductions of about one tenth each week. Judging by abstinence at 12 months of treatment attendance the experimental fixed withdrawal rate group had a 46% completion rate while the 'traditional taper' control group yielded 70%, a significant difference. The reductions in overall benzodiazepine use were good, better in the control taper group (but not significantly). Full benzodiazepine abstinence was achieved in 27% in the control group and 13% in the experimental group. There were reductions in overall benzodiazepine use by 45- 80% across the groups. One in six subjects demonstrated no reductions over 12 months despite the treatment interventions.

Although there is no 'gold standard' treatment for tranquillizer addiction, most of us use some degree of diazepam prescribing with psychosocial support and this study shows again the need for prescribing flexibility to obtain the best outcomes.

Dr Fixit - Naltrexone following detoxification

Thank you with your help with John (see last issue). The buprenorphine detox went very well and he went into rehab on 0.4mgs of buprenorphine which he stopped after a week. He found rehab useful but very hard and left after 2 weeks. He is now opiate free and back home. He has heard of naltrexone and would like to try it. He is anxious about taking a tablet every day, has had a friend who was helped by having an implant and wants to know about having one himself. I have prescribed oral naltrexone before and understand the drug but I have never heard about naltrexone implants. Could you advise me whether this would be an appropriate option and if so how I should proceed?

Answer by Lucy Cockayne, Chris Ford and Jenny Sudell
Your patient has made an interesting choice and we will try to advise you. Although naltrexone implants are not licensed and as yet there is an absence of an evidence base, they are becoming recognised as useful in terms of helping to prevent relapse. An implant may be useful for patients like John who have previously relapsed. The implants are not expensive in comparison to in-patient rehabilitation, prison time, or on-going supervised substitute prescribing. ***For full discussion and more information see article by Lucy Cockayne on page 6 & 7.***

The first things to do would be to undertake an assessment, confirm opiate dependency, explore motivation, offer full explanation regarding this treatment choice, and obtain patient consent. Following this, the GPs role in most instances is likely to be one of referral. Consent should include a full explanation of all the potential problems associated with treatment. Some of these are as yet unknown, since studies have not yet been carried out, and so this needs to be explained in terms a patient can understand. Motivation needs to be assessed, but most importantly and most commonly overlooked is the need for full explanations about the turmoil of feelings associated with abstinence from a drug that has been the patients "best friend" for maybe many years. Patients will need follow up, possible implant replacement or removal and access to aftercare services.

Naltrexone implants have been undertaken within NHS practice settings with the usual facilities and support available to most GPs. The GP would need to have undertaken training and have the support of a practice nurse that feels competent to assist. This may be appropriate for an experienced GPwSI level GP, but not for generalist level. On the whole PCTs are not funding this type of service at the moment. In one scenario, due to an absence of PCT funding this gave rise to the development of a GP led private service. Another example is a GP in London who refers on to an out of area private clinic and has managed to get the specialist service and the PCT to pay for a handful of well-motivated patients who have undergone thorough assessments. These patients have all done well with currently one patient on a 6/12 implant and another on his second 6/12 implant.

We would suggest if after assessing John you feel it is right to proceed, then find out about available services, make a case in terms of the patient and cost benefits for PCT or local funding. Let us know how you get on. For information on services providing implants contact SMMGP – contact details on page 8.

Dr Fixit - Going on holiday

Sally, a patient of mine wants to go on holiday to Spain for two weeks, with her two children. She is a stable drug user on methadone maintenance of 100mls daily, which she picks up daily from the pharmacy. Regular urines confirm that she uses no additional drugs other than cannabis. I am not sure how to proceed and whether I can agree to let her take 1400mls of methadone. Can you advise?

Answer by Dr Chris Ford and Dr Jenny Keen
Your patient, Sally sounds like she is doing really well and we would suggest supporting her to go on holiday by arranging the necessary license and giving good advice.

A Home Office export licence is required for anyone wishing to travel abroad with amounts in excess of 500mgs methadone. Sally needs to provide proof of travel and then you need to fax a letter to the Home Office on 020 72732157 or post to: Home Office, Drugs Branch, Queen Anne's Gate, London SW1H 9AT giving at least 14 days notice. The letter needs to clearly state the name and address of the person travelling, date of birth, the quantity of drugs to be carried, the strength and form in which the drugs will be dispensed and the dates of travel to and from the UK.

The licence only permits export, it does not guarantee that the country being travelled to will access the person and their drugs into the country. This should be clearly explained to the patient. Spain will allow the import of methadone but some other countries will not allow the import of all controlled drugs and some others will only permit certain drugs.

Safety on holiday - Remember to remind her of the dangers of methadone to non-tolerant individuals and children in particular. Even on holiday she needs to pay close attention to safe storage where her own and other people's children cannot get hold of the methadone by accident. At the risk of being a killjoy, she also needs to remember that methadone and excessive alcohol is a very dangerous combination!

For Information

The information below is based on Home Office information that can become out of date. The definitive answer to whether a Controlled Drug (CD) is allowed to be imported in a foreign country rests with the embassy or the consulate of that country in the UK. Confirming with embassies will allow the GP to give accurate up to date advice even for the more esoteric destinations.

Countries that will not allow any CDs to be imported for personal use are: Italy and Netherlands (clients can obtain CDs in Holland, but it may help if they carry letter from UK doctor).

Countries that do not allow the import of diamorphine and methadone: Greece.

Countries that do not allow the import of diamorphine: Australia, France, Germany, South Africa, U.S.A., Japan and Zimbabwe.

Countries that do not allow the import of methadone: Belgium, but methadone can be obtained in Belgium. Clients need to carry a prescription from a UK doctor, submit this to a Belgian doctor to transcribe onto Belgian prescription for dispensing.

The Tom Waller Harm Reduction Award

The Tom Waller Award was presented to Dr Chris Ford at the UK Harm Reduction Association (UKHRA) annual conference in June 2003. This UKHRA award, now named after the inaugural winner, was made in recognition of Chris Ford's significant contribution to the development of harm reduction policy and practice in the UK. With the first two award winners being GPs, this additionally represents a recognition of the important role of primary care practitioners in the drugs field.

Bulletin Board

9th National Conference: RCGP Management of Drug Users in General Practice - Cardiff City Hall, Cardiff, Thursday & Friday, 20 & 21 May 2004. This two-day conference is the platform for the on-going debate on managing drug users in general practice. Primary care focussed, and multi-disciplinary in philosophy, this conference has become an essential focal point for, GPs, shared-care workers, specialists and drug-users to come together to promote and examine current debates and models of best practice for management of drug users. This year, the conference attracted over 330 delegates — and was fully booked months before — so you are advised to book early for 2004. To be sent the programme please complete and return the form enclosed with this newsletter. Or email your details to charlotte@healthcare-events.co.uk

Crack and Methadone Guidance for Primary Care - SMMGP, the RCGP and the NTA are developing crack guidance and about to start developing methadone guidance along the lines of the existing buprenorphine guidance for primary care (see this guidance at www.smmgp.demon.co.uk/download/articles/art016.pdf). A crack discussion day took place at the RCGP in July to pool experience and start off the development process bringing together interested and experienced practitioners, professionals and users. A similar methadone day will take place at the RCGP on Wednesday 12th November 2003. It is expected to launch the crack guidance for primary care at the 2004 GP conference (detailed above). If you would like to comment on the developing crack guidance then contact Monique Tomlinson on moniquetomlinson@wdi.co.uk. If you would like to attend the Methadone Pooled Experience Day please write to Christine Vaughan on CVaughan@rcgp.org.uk ***NB Please note this is NOT a training day and is to begin developing the guidance – attendees need to have experience of methadone and/or treating drug users in primary care.***

***Still Working with Substance Users in Primary Care* conference** Aimed at GP liaison workers, this conference would be of interest to a wider audience. Presentations include heroin prescribing, engaging GPs, buprenorphine prescribing, Models of Care. Workshops range in topic from Hep C, amphetamines and crack, to user involvement. Friday 17th October at the GMB National College, Whalley Range Manchester. Contact Mark Birtwistle at SMMGP on 0161 905 8581 or mark@smmgp2.demon.co.uk

Viewpoint

A response to the heroin guidance Injectable heroin (and injectable methadone): potential roles in drug treatment viewpoint

After widespread consultation and examination of the evidence, the Home Secretary, David Blunkett, and the Home Affairs Select Committee have pushed to see heroin prescribing more widely available as a treatment option. The National Treatment Agency has been charged with the task of operationalizing that expansion in treatment and has produced a guidance report *Injectable heroin (and injectable methadone): potential roles in drug treatment*. Peter McDermott, user activist, voices a discussion of concerns regarding the issues and the NTA guidance report, on the Lifeline website www.lifeline.org.uk. We include an excerpt below as this issue's Viewpoint:

'We do not believe that there is a lack of evidence in regard to the various efficacies of heroin maintenance treatment in the UK. We believe that Micheson and Hartnoll's research in the early 80's accurately identified the various trade-offs that are involved in this particular treatment modality. Heroin maintenance, generally speaking, will result in retention in treatment, a reduction in offending behaviour and some improved health gains. The costs of these gains are that the patient is less likely to achieve abstinence although some patients will do so.

We are also aware that one of the consequences of not making this treatment option available is the continued existence of a group of people who do not engage with treatment. This group will have the highest rates of offending and will be most susceptible to infection from blood-borne viruses and early death. Because some of them will continue to sell drugs in order to fund their addiction, they will play a vested role in expanding the numbers of people who are dependent on the trade in black market heroin.

While it was inevitable that this guidance was going to be relatively conservative, we believe that this form of the guidance is so conservative as to be unusable. Rather than expanding these varieties of specialist treatment, we believe that the effect of this guidance will be the exact opposite to the intended outcome, and that rather than increasing, the number of people receiving these treatment options will continue to contract. This was not the intention of the Home Secretary, or of the Home Affairs Select Committee. Furthermore, we do not believe that it was the intention of the National Treatment Agency. We feel that the composition of the NTA's expert treatment group that issued this particular guidance was drawn from a far too narrow group of specialists, and it is likely that at least some members of this group are opposed to an expansion of this treatment option on principle. In light of that, we feel that these guidelines should provide the basis for the start of a debate on these issues within the drug treatment field as a whole, and we offer this paper as a contribution to the beginning of that debate.' **Peter McDermott,** Monday, 23 June 2003

See full discussion on www.lifeline.org.uk. Lifeline welcomes any comments which will be posted on its web page.
See the full NTA report on
www.nta.nhs.uk/guidance/prescribing/HeroinFullGuideFinal.pdf

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